TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Bayshore Medical Center

Respondent Name
LM Insurance Corp

MFDR Tracking Number
M4-16-2148-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
March 25, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "it is the position of the Hospital that all charges relating to the admission of this claimant are due and payable and not subject to the improper reductions taken by the Carrier on this case."

Amount in Dispute: $1,777.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Liberty Mutual believes that Bayshore Medical Center has been appropriately reimbursed for services render to (claimant) for the date of service 07/10/2015."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 20, 2015	Outpatient hospital services	$1,777.28	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
    - P12 – Workers compensation jurisdictional fee schedule adjustment
    - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
    - X901 – Documentation does not support level of service billed

Issues

1. Is the carrier's denial supported?
2. What is the Medicare payment rule?
3. What is the applicable rule that pertains to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The services in dispute are for Outpatient Hospital Services with dates of service July 20, 2015. 28 Texas Administrative Code 134.403 (d) states in pertinent part,

    > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided…

The carrier denied this disputed service as X901 – "Documentation does not support level of service billed." Per Medicare CCI coding edits, procedure code 93005 reported with procedure code 26540 billed on the same claim when submitted with the -59 modifier must meet the following: "Documentation that supports a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual." Insufficient documentation was found to support the requirements of the -59 modifier were met. Therefore, the insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

2. 28 Texas Administrative Code 134.403 (f) states in pertinent part,

    > The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register.

The Medicare Claims processing Manual found at www.cms.hhs.gov, Chapter 4, Section 10, defines the terms, Status Indicators and APC Payment Groups as follows:

> **10.1.1 - Payment Status Indicators**
>
> *An OPPS payment status indicator is assigned to every HCPCS code. The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. For example, services with status indicator A are paid under a fee schedule or payment system other than the OPPS. Services with* ***status indicator N are paid under the OPPS, but their payment is packaged into payment for a separately paid service.*** *Services with status indicator T are paid separately under OPPS but a multiple procedure payment reduction applies when two or more services with a status indicator of T are billed on the same date of service.*
>
> *The full list of status indicators and their definitions is published in Addendum D1 of the OPPS/ASC proposed and final rules each year. The status indicator for each HCPCS code is shown in OPPS Addendum B.*

10.2 - APC Payment Groups

Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. (See section 10.5 for discussion of multiple procedure discounting under the OPPS).

The Medicare facility specific reimbursement amount is explained at, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf as:

"The payment rates for most separately payable medical and surgical services are determined by multiplying the prospectively established scaled relative weight for the service's clinical APC by a conversion factor (CF) to arrive at a national unadjusted payment rate for the APC. The scaled relative weight for an APC measures the resource requirements of the service and is based on the geometric mean cost of services in that APC. The CF translates the scaled relative weights into dollar payment rates.

To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) ***is further adjusted by the hospital wage index*** *for the area where payment is being made. The remaining 40 percent is not adjusted. You may also receive the following payments in addition to standard OPPS payments:"*

The facility specific reimbursement amount is calculated as follows:

Payment rate found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html

Procedure Code	APC	Status Indicator	Payment Rate	60% labor related	2015 Wage Index Adjustment for provider	40% non-labor related	Payment
71020	260	Q3	$59.37	$59.37 x 60% = $35.62	$35.62 x 0.9679 = $34.48	$59.37 x 40% = $23.75	$34.48 +$23.75 = $58.23
49505	0154	T	$2,675.43	$2,675.43x 60% = $1,605.26	$1,604.63 x 0.9679 = $1,553.73	$2,675.43 x 40% = $1,070.17	$1,553.73 + $1,070.17 = $2,623.90

3. 28 Texas Administrative Code 134.403 (f) states in pertinent part,

The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

Review of the submitted medical claim finds implants were not requested and no outlier payment is due. The maximum allowable reimbursement for the services in dispute listed on DWC 60 is calculated as follows:

- Procedure code J7120 has a status indicator of N, no separate payment allowed.
- Procedure code C1781 has a status indicator of N, no separate payment allowed.
- Procedure code 80053 has a status indicator of N, no separate payment allowed.
- Procedure code 85027 has a status indicator of N, no separate payment allowed.
- Procedure code 71020 the total Medicare facility specific reimbursement amount for this line is $58.23. This amount multiplied by 200% yields a MAR of $116.46.
- Procedure code 49505 the total Medicare facility specific reimbursement amount for this line is $2,623.90. This amount multiplied by 200% yields a MAR of $5,247.80.
- Procedure code J1580 has a status indicator of N, no separate payment allowed.
- Procedure code 93005 has a status indicator of Q1, which denotes STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date.

4. The total allowable reimbursement for the services in dispute is $5,364.26. This amount less the amount previously paid by the insurance carrier of $5,364.26 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		April , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.